

EXHIBIT W

**OF THE DIVISION OF MEDICAID & MEDICAL ASSISTANCE (DMMA)
MANAGED CARE ORGANIZATION (CONTRACTOR)
CONTRACT FOR DIAMOND STATE HEALTH PLAN (DSHP)
AND DSHP PLUS**

I. ADMINISTRATIVE STANDARDS

This Exhibit provides the case management process and administrative contractual standards for DSHP Plus members meeting the institutional level of care requirement and who reside in a nursing facility or in the community. In this Exhibit, those DSHP Plus members who are residing in the community and were eligible for or receiving services under the Elderly & Physically Disabled 1915c Home & Community-Based Waiver program or the AIDS 1915c Waiver will be identified as the EPD/A members. This Exhibit does not apply to the DSHP Plus members who are Medicare/Medicaid dual eligibles residing in the community and do not meet the nursing facility level of care criteria.

Administrative responsibilities related to case management of enrolled members include the following:

A. Case Manager Qualifications

1. Individuals hired as case managers must be either:
 - a. Individuals with a Bachelors degree in health, human, social work or education services with one or more years of qualifying experience; or three years of qualifying experience with case management of the aged, including management of behavioral health conditions; or persons with physical or developmental disabilities; or AIDS/HIV population.
 - b. Licensed as an RN; or LPN with two years of qualifying experience with appropriate supervision according to Delaware Regulations Title 24 section 1900 7.4.1.4.2.
2. Case managers must have knowledge or experience in:
 - a. Interviewing and assessing members;
 - b. Caseload management and casework practices;
 - c. Human services principles for determining eligibility for benefits and services;
 - d. Federal and State rules and regulations as they apply to human services programs;
 - e. Ability to effectively solve problems and locate community resources.
 - f. Good interpersonal skills.

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3. The Contractor must maintain case manager staffing ratios of:
 - a. 1:120 for Nursing Facility members; 1:60 for members receiving home and community based services; dual eligibles; and assisted living. Members receiving Money Follows the Person (MFP) services are required to be case managed at a ratio of 1:30.
 - b. Case management must be provided at a level dictated by the complexity and required needs of the member.

B. CASE MANAGEMENT PROCEDURES

Contractors are responsible for maintaining case management procedures that are reflective of DSHP PLUS policy, as defined in this Exhibit and the MCO Contract, Chapter II.

Unless otherwise directed by the State, standardized forms for Contingency Plans and Back-Up; Member Service Plan; and Member Change Reports shall be reviewed, approved and developed jointly by DMMA and the Contractors as part of the Implementation Team Meeting process. The Contractors may develop their own standardized forms and tools for assessing and recording information regarding members' needs and services.

Guidelines to be used in developing and implementing an assessment tool or process for personal care/attendant care (including participant-directed services) will be developed as part of the Implementation Team Meeting process.

C. TRAINING

Case managers must be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used must be maintained.

1. Contractors must ensure that there is a structure in place to provide uniform training to all case managers. This plan should include formal training classes as well as mentoring-type opportunities for newly hired case managers.
2. Newly hired case managers must be provided orientation and training in a minimum of the following areas:
 - a. The role of the case manager in utilizing a member-centered approach to DSHP PLUS case management, including involving the member and their family in decision-making and service planning
 - b. The principle of most integrated, least restrictive settings for member placement
 - c. Member rights and responsibilities

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- d. Case management responsibilities as outlined in this Exhibit, including, but not limited to service planning, contingency plans, reporting service gaps and Notices of Action.
 - e. Case management procedures specific to the Contractor
 - f. An overview of the DSHP PLUS program
 - g. The continuum of DSHP PLUS services, including available service settings and service restrictions/limitations
 - h. The Contractor provider network by location, service type and capacity. Included in this should be information about community resources for non-DSHP PLUS covered services.
 - i. Information on local resources for housing, education and employment services/program that could help members gain greater self-sufficiency in the areas.
 - j. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect and/or exploitation
 - k. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the DSHP PLUS population service by the Contractor.
 - l. General social service information, such as family dynamics, care contracting, dealing with difficult people.
 - m. Behavioral health information, including identification of member's behavioral health needs, covered behavioral health services and how to access those services within the Contractor's network and the requirements for initial and quarterly behavioral health consultations.
 - n. Pre-Admission Screening and Resident Review (PASRR) process that is completed by DMMA LTC Eligibility Operations.
 - o. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for members under the age of 21.
3. In addition to review of areas covered in orientation, all case managers must also be provided with regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:
- a. Policy updates and new procedures
 - b. Refresher training for areas found deficient through the Contractor's internal monitoring process
 - c. Interviewing skills
 - d. Assessment/observation skills
 - e. Cultural competency
 - f. Member rights
 - g. Medical/behavioral health issues, and/or
 - h. Medications – side effects, contraindications and poly-pharmacy issues.

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4. Training may also be provided by external sources, for example:
 - a. Consumer advocacy groups
 - b. Providers (for example, medical or behavioral health), and
 - c. Accredited training agencies.
5. The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources within the Contractor's service area. This individual must be available to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options.

D. CASELOAD MANAGEMENT

Adequate numbers of qualified and trained case managers must be provided to meet the needs of enrolled members.

Contractors must have written protocols to ensure newly enrolled DSHP PLUS members are assigned to a case manager immediately upon enrollment.

1. Elderly and/or Physically Disabled and AIDS (EPD/A) Members:

Each case manager's caseload must not exceed a weighted value of 120. The following formula represents the maximum number of members allowable per EPD/A case manager:

 - a. For institutionalized members, a weighted value of **1** is assigned. Case managers may have up to 120 institutionalized members ($120 \times 1 = 120$).
 - b. For HCBS (living in their own home) members, a weighted value of **2** is assigned. Case managers may have up to 60 HCBS members ($60 \times 2 = 120$).
 - c. For MFP members, a weighted value of **4** is assigned. Case managers may have up to 30 MFP members ($30 \times 4 = 120$).
 - d. If a mixed caseload is assigned, there can be no more than a weighted value of 120. The following formula is to be used in determining a case manager's mixed caseload:

$$\begin{array}{r} (\# \text{ of HCBS members} \times 2) \\ + \\ (\# \text{ of MFP members} \times 4) \\ + \\ (\# \text{ of NF members} \times 1) \\ \hline 120 \text{ or less} \end{array}$$

2. Caseload Exceptions:

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Program Contractors must receive authorization from DMMA Medical Management and Delegated Services prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established at the discretion of the Contractor and do not require authorization.

The Contractor's annual Case Management Plan must describe how caseloads will be determined and monitored.

E. Accessibility

Members and/or member representatives must be provided adequate information in order to be able to contact the case manager or Contractor office for assistance, including what to do in cases of emergencies and/or after hours.

A system of back-up case managers must be in place and members who contact an office when their primary case manager is unavailable must be given the opportunity to be referred to a back-up for assistance.

There must be a mechanism to ensure members, representatives and providers are called back in a timely manner when messages are left for case managers.

F. Time Management

Contractors must ensure that case managers are not assigned duties unrelated to member-specific case management for more than 15% of their time if they carry a full caseload.

G. Technical

Contractors must ensure that case managers do not provide direct, reimbursable services to DSHP PLUS members enrolled with the Contractor.

H. Supervision

A supervisor to case manager ratio must be established that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers.

A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of member assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to DMMA Medical Management and Delegated Services upon request.

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I. Inter-Departmental Coordination

The Contractor should establish and implement mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with medical management (MM) and quality management (QM). For example, there should be coordination of information between case management, MM and QM regarding poly-pharmacy issues to ensure that measures are taken to effectively address this issue.

The Contractor should ensure the Medical Director is available as a resource to case management and that s/he is advised of medical management issues as needed.

J. Monitoring and Reporting Requirements

1. Monitoring

The Contractor shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations (inter-rater reliability). The Contractor shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. This information shall be submitted to DMMA on a quarterly basis, 60 days after the close of each quarter, and within timeframes established in the Quality Management Strategy (QMS, Exhibit E) for current monthly and quarterly DSHP reporting.

2. Case Management Plan

A Case Management Plan must be submitted annually to DMMA according to the current DSHP timeframes in the Quality Management Strategy (MCO Contract, Exhibit E) by all Contractors. The plan must address how the Contractors will implement and monitor the case management and administrative standards outlined in this Exhibit, including specialized caseloads. The plan must also describe the methodology for assigning and monitoring case management caseloads.

An evaluation of the Contractor's Case Management Plan from the previous year must also be included in the plan, highlighting lessons learned and strategies for improvement.

II. CASE MANAGER STANDARDS

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The case manager provides intensive case management for DSHP Plus members in need of long term care services through service planning and coordination to identify services; brokering of services to obtain and integrate services; facilitation and advocacy to resolve issues that impede access to needed services; monitoring and reassessment of services based on changes in a member's condition; and gate keeping to assess and determine the need for and cost effectiveness of services to members.

A. INITIAL CONTACT/VISIT STANDARD

1. Within seven (7) business days of a new member's enrollment, the assigned case manager, or designee, must initiate contact with the member or member representative. In addition, if the member resides in a nursing facility or other residential setting, the case manager, or designee, will contact the facility to inform the facility of the member's enrollment. Initial contact may be made via telephone, a face-to-face visit or by letter, if the case manager is unable to contact the member by other approaches.

An on-site visit to initiate service planning must be completed by the case manager within 12 business days of the member's enrollment. If information obtained during the initial contact or from the Pre-Admission Screening Tool completed by DMMA during the eligibility determination indicates the member has more immediate needs for services, the on-site visit should be completed as soon as possible.

The interview must be conducted at the member's place of residence or a hospital or nursing home in order to develop the member's service plan. Confirmation of the scheduled interview is recommended prior to the meeting.

The member must be present for, and be included in, the on-site visit. The member representative must be contacted for care planning, including establishing service needs and setting goals, if the member is unable to participate due to cognitive impairment, the member is a minor child and/or the member has a legal guardian.

2. If the case manager is unable to locate/contact a member via telephone, visit or letter, or through information from the member's relatives, neighbors or others, another letter requesting that the member contact the case manager should be left at, or sent to, the member's residence. If there is no contact within 30 calendar days from the member's date of enrollment, the case must be referred to the member's DSHP Plus Long Term Care (LTC) Eligibility section via e-mail or phone call for potential loss of contact. A central point of contact and method of contact will be developed. DMMA will develop, in conjunction with the Contractors, a uniform Member Change Reporting form, during the Implementation Team Meeting process. The form will be submitted by the Contractors for reporting loss of contact and member disenrollment requests.

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3. All contact attempted and made with, or regarding, a DSHP Plus member must be documented in the member's case file.
4. The case manager is responsible for explaining the member's rights and responsibilities under the DSHP Plus program to the member or member representative, including the procedures for filing a grievance and/or an appeal. A copy of these rights and responsibilities must also be provided in writing (generally via the Member Handbook). The member or member representative must sign and date a statement indicating that they have received the member rights and responsibilities in writing, that these rights and responsibilities have been explained to them and that they clearly understand them.

B. NEEDS ASSESSMENT/CARE PLANNING STANDARD

1. Case managers are expected to use a person-centered approach regarding the member assessment and needs, taking into account not only covered services, but also other needed community resources as applicable. Case managers are expected to:
 - a. Respect the member's rights.
 - b. Provide adequate information and guidance to assist the member/family in making informed decisions and choices.
 - c. Provide a continuum of service options that supports the expectations and agreements established through the care plan process.
 - d. Educate the member/family on how to report unavailability or other problems with service delivery to the Contractor in order that unmet needs can be addressed as quickly as possible. See also subsections on 4. Placement and Planning Standards and 5. Service Plan Monitoring and Assessment in this policy regarding specific requirements.
 - e. Facilitate access to non- medical services available throughout the community.
 - f. Advocate for the member and/or family/significant others as the need occurs.
 - g. Allow the member/family to identify their role in interacting with the service system.
 - h. Provide members with flexible and creative service delivery options.
 - i. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering and monitoring services.
 - j. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member and
 - k. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education and employment.

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2. The involvement of the member and member's family in strengths/needs identification as well as decision making is a basic tenet of case management practice. The member, family, and/or significant others are partners with the case manager in the development of the plan with the case manager in the facilitating mode.
3. Care planning is based on:
 - a. Face-to-face discussion with the member and/or member representative that includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas:
 - i. Functional abilities
 - ii. Medical conditions
 - iii. Behavioral health
 - iv. Social/environmental/cultural factors, and
 - v. Existing support system.
 - b. Recommendations of the member's primary care provider (PCP)
 - c. Input from service providers, as applicable, and
 - d. Pre-admission evaluation (PAE), available from DMMA LTC.
4. Together, the case manager and member must develop goals that address the issues that are identified in the care planning process. Goals should be built on the member's strengths and include steps that the member will take to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.
5. Member goals must:
 - a. Be member specific.
 - b. Be measurable.
 - c. Specify a plan of action/interventions to be used to meet the goals.
 - d. Include a timeframe for the attainment of the desired outcome, and
 - e. Be reviewed at each assessment visit and progress must be documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.

C. COST EFFECTIVENESS OF SERVICES

Services provided under the Title XIX must be cost effective whether the placement is in an institutional facility or a HCBS setting. The Contractors must assess the cost effectiveness of the package of services for all members with potential for placement in a home and community based services (HCBS) setting and for those EPD/A members

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currently placed in an institutional setting who have discharge potential. The cost effectiveness of services must be reviewed at least annually for all HCBS members. If the package of HCBS for a member exceeds 80% of the institutional cost of care for the member, the case manager must review the services with the case management supervisor for CONTRACTOR authorization. If the package of HCBS for a member is equal to or greater than 100% of the institutional cost of care for the member, the Contractors must report these members on a monthly basis to DMMA including the member's name, Medicaid ID, service package cost, institutional cost estimate, and mix of HCBS authorized, the reason(s) costs are exceeding the cost of institutional care, and if and when costs are expected to drop below the cost of institutionalization. The format and timing of the monthly report will be determined jointly by DMMA and the Contractors during the Implementation Team Meeting process.

D. PLACEMENT/SERVICE PLANNING STANDARD

The case manager is responsible for facilitating placement/services based primarily on the member's choice. Additional input in the decision-making may come from the member's guardian/family/significant other, the case manager's assessment, the Pre-Assessment Evaluation, the members PCP and/or other service providers.

A guiding principle of the program is that members are placed and/or maintained in the most integrated/least restrictive setting.

1. After the needs assessment is completed, the case manager must discuss the cost effectiveness and availability of needed services with the member and/or member representative.
2. In determining the most appropriate service placement for the member, the case manager and the member and/or the member representative should discuss the following issues as applicable:
 - a. The member's placement choice
 - b. Services necessary to meet the member's needs in the most integrated setting:
 - i. Home and community based services (HCBS) See CONTRACTOR contract Chapter II section 7.5 Diamond State Health Plan Plus Benefit Package for a comprehensive list of services;
 - ii. Institutional services documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement;
 - iii. Acute care services, and;
 - iv. Behavioral health services.
3. The availability of HCBS in the member's community

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4. The option to elect consumer direction to self-direct personal care/attendant services must be discussed with the member by the case manager and documented in the case file.
 - i. Informing and educating members and/or legal representatives about consumer direction of personal care/attendant services option including verifying that members electing consumer directed personal care understand their roles and responsibilities. Evidence of such discussion must be included in case notes.
 - ii. Referring interested members and/or legal representatives to available resources for further information about and/or facilitating member participation in opting for self-direction of their personal care/attendant services. Support for consumer direction combines two functions: financial management services (FMS) and information and assistance in support of consumer direction (support brokerage).
 - iii. Advising the member as needed regarding the hiring and training of the personal care/attendant care worker (P/ACW).
 - iv. Assisting the member to assess his/her training needs and authorizing training based on that assessment as appropriate.
 - v. Assisting the member as needed in finding a replacement worker (generally from an agency) to provide services when the member reports that the P/ACW is unavailable and the member requests assistance.
 - vi. Services need to be provided within the timelines specified by the member's service preference level.
 - vii. Facilitating any needed transition from the consumer directed personal/attendant care service option to traditional service delivery system or transition back to consumer directed personal/attendant care when requested and appropriate.
5. Cost effectiveness of the member's placement/service choice.
6. Covered services which are associated with care in a nursing facility compared to services provided in the member's home or another HCBS setting.
7. The member's Patient Pay Amount (PPA) responsibility. The PPA is the amount of the member's income that s/he must pay towards the cost of long term care services. The amount of the member's PPA is determined and communicated to the member by DMMA.
8. The member's room and board (R & B) responsibility. Since Delaware Medicaid does not cover R & B in a HCBS alternative residential setting, this portion of the cost of the care in these settings must be paid by the member or other source (such as the member's family). The monthly R & B amount is determined by and communicated to the member by the CONTRACTOR.
9. Any member who lives in his/her own home must be allowed to remain in his/her own home as long as HCBS are cost effective. Members cannot be required to enter an alternative residential placement/setting that is "more" cost effective.

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10. Upon the member's or member representative's agreement to the service plan, the case manager is responsible for coordinating the services with appropriate providers.

Placement within an appropriate setting and/or all services to meet the member's needs must be provided as soon as possible. A decision regarding the provision of services requested must be made within 14 calendar days following the receipt of the request/order (3 business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized). Refer to Title 42 of the Code of Federal Regulations (42 C.F.R.) 438.210 for more information.

Services determined to be medically necessary for a newly enrolled member must be provided to the member within 30 calendar days of the member's enrollment. Services for an existing member must be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

DSHP Plus Contractors shall develop a standardized system for verifying and documenting the delivery of services with the member or representative after authorization.

11. The case manager must ensure that the member or representative understands that some long term care services (such as home health nurse, home health aide or durable medical equipment (DME) must be prescribed by the PCP. A decision about the medical necessity of these services cannot be made until the PCP writes an order for them. All orders for medical services must include the frequency, duration and scope of the service(s) required, when applicable.
12. If a DSHP Plus member does not have a PCP or wishes to change PCP, it is the case manager or designee's responsibility to coordinate the effort to obtain a PCP or to change the PCP.
13. The case manager must also verify that the needed services are available in the member's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of personal care or home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.
14. The case manager is responsible for developing a written service plan that reflects services that will be authorized. The Service Plan Form to be used by each CONTRACTOR must be reviewed and approved by DMMA during the Implementation Team meeting process. The Service Plan Form must document the

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process for member grievance and appeals and clearly explain the timeframes and process to the member. It must be noted for each service whether the frequency/quantity of the service has changed since the previous service plan. The member or representative must indicate whether they agree or disagree with each service authorization and sign the service plan at initial development, when there are changes in services and at the time of each service review (every 90 or 180 days). The case manager must provide a copy of the service plan to the member or representative and maintain a copy in the case file.

If the member disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the member with a written notice of action that explains the member's right to file an appeal regarding the placement or service plan determination. Refer to DSHP CONTRACTOR Contract Chapter 11.11 Grievance System.

15. The Contractors shall develop a form for use as a Contingency and Back-Up Plan for DHSP Plus members. This form shall be reviewed, approved and developed jointly by DMMA and the Contractors as part of the Implementation Team Meeting process. The DSHP Plus Member Contingency and Back-Up Plan must also be completed for those members who will receive any of the following important HCBS services that allow the member to remain in their own home:
- a. Personal Care/Attendant Care Services, including participant directed services
 - b. Homemaker, and/or
 - c. In-home respite
 - d. Nursing

A gap in in-home HCBS is defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of in-home HCBS that are actually delivered to the member.

The following situations are not considered gaps:

1. The member is not available to receive the service when the caregiver arrives at the member's home at the scheduled time
2. The member refuses the caregiver when s/he arrives at the member's home, unless the caregiver's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (for example, drug and/or alcohol intoxication)
3. The member refuses services

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4. The provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes unavailable.
5. The member and regular caregiver agree in advance to reschedule all or part of a scheduled service, and/or
6. The caregiver refuses to go or return to an unsafe or threatening environment at the member's residence.

The contingency plan must include information about actions that the member and/or representative should take to report any gaps and what resources are available to the member, including on-call back-up caregivers and the member's informal support system, to resolve unforeseeable gaps (e.g., regular caregiver illness, resignation without notice, transportation failure, etc.) within three hours unless otherwise indicated by the member. **The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice.** An out-of-home placement in a NF or ALF should be the last resort in addressing gaps.

The CONTRACTOR contingency plan must include the telephone numbers for provider and/or Contractor that will be responded to promptly 24 hours per day, 7 days per week.

In those instances where an unforeseeable gap in in-home HCBS occurs, it is the responsibility of the CONTRACTOR to ensure that in-home HCBS are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the member or representative before the scheduled service to advise him/her that the regular caregiver will be unavailable, the member or representative may choose to receive the service from a back-up substitute caregiver, at an alternative time from the regular caregiver or from an alternate caregiver from the member's informal support system. **The member or representative has the final say in how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.**

When the DMMA provider or CONTRACTOR is notified of a gap in services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to

- The reason for the gap, and
- The alternative plan being created to resolve the particular gap and any possible future gaps.

16. The written contingency plan for members receiving those in-home HCBS described above must include a Member Service Preference Level from one of the four categories shown below:

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- a. Needs service within three hours
- b. Needs service today
- c. Needs service within 48 hours, or
- d. Can wait until the next scheduled service date.

Member Service Preference Levels must be developed in cooperation with the member and/or representative and are based on the most critical in-home service that is authorized for the member. The Member Service Preference Level will indicate how quickly the **member chooses** to have a service gap filled if the scheduled caregiver of that critical service is not available. The member or representative must be given the final say about how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

The case manager should assist the member or representative in determining the member's Service Preference Level by discussing the member's caregiving needs associated with his/her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs, such as housekeeping, meal preparation and grocery shopping), abilities and cognitive, behavioral and medical status. The case manager should ensure the member or representative has considered all appropriate factors in deciding the member's Service Preference Level. The member/representative is not required to take into account the presence of an informal support system when determining the Service Preference Level.

The case manager must document the Member Service Preference Level chosen in the case file. This documentation must clearly indicate the member's or representative's involvement in contingency planning.

A member or representative can change the Service Preference Level from a previously determined Service Preference Level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor must discuss the current circumstances with the member or representative at the time the gap is reported to determine if there is a change in the Service Preference Level. The plan to resolve the service gap must address the **member's choice** at the time the gap is reported.

The contingency plan must be discussed with the member/representative at least quarterly. A copy of the contingency plan must be given to the member when developed and at the time of each review visit. The member/representative may change the member Service Preference Level and his/her choices for how service gaps will be addressed at any time.

- A. 17. Members who reside in "own home" settings should be encouraged, and assisted as indicated, by the case manager to have a disaster/emergency plan for their household that considers the special needs of the member. Informational materials

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are available at the Federal Emergency Management Agency's (FEMA) website at www.fema.gov or www.ready.gov. Members should also be encouraged to register with the State's Emergency Preparedness Voluntary Registry. For more information go to <http://www.de911assist.delaware.gov/>.

18. Members who reside in out-of-home residential placements must be regularly assessed to determine if they are in the most integrated setting possible for their needs. Members should be allowed or encouraged to change to a less restrictive placement, as long as needed services are available and cost effective in that setting.
19. If the member will be admitted to a nursing facility, the case manager must ensure and document that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and Level II evaluation, if indicated, have been completed prior to admission by DMMA LTC Operations.
20. If the member does not intend to pursue receiving HCBS or institutional services, the member needs to be encouraged to withdraw from the DSHP Plus program voluntarily and seek services through a DMMA acute care Contractor or other programs.
21. The service plan must include the date range and units for each service authorized in the member's case file according to the CONTRACTOR's system for tracking service authorizations.
22. Service plans for members residing in an Institutional Setting must include the following types of services (also including services under CONTRACTOR contract Chapter II section 7.5 DSHP Plus Benefit Package), as appropriate based on the member's needs:
 - a. Nursing facility services. The service plan must indicate the level of care based on the Pre-admission evaluation or for any specialty that may have been negotiated between the Nursing Facility and Contractor.
 - b. Hospital admissions (acute and psychiatric)
 - c. Bed hold or therapeutic leave days
 - e. DME not included under the institutional facility per diem
 - f. Hospice services
 - g. Therapies (occupational, physical and speech)
 - h. Medically necessary non-emergency transportation
 - j. Behavioral health services
 - k. Title XIX covered services as noted above if provided by other funding sources, for example, Medicare and other insurance sources.

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23. Service plans for members residing in an **HCBS setting** must include the following types of services (also including services under CONTRACTOR contract Chapter II section 7.5 DSHP Plus Benefit Package), as appropriate, based on the member's needs:
- a. Adult Day Services or Day Habilitation
 - b. Hospital admissions (acute and psychiatric)
 - c. Personal Care/Attendant Care Services (including participant directed services)
Service Code modifiers for encounter submissions may be developed during Implementation Team Meetings to be used to distinguish the type of Attendant Care when and if provided:
 - i. by family living with the member
 - ii. by family not living with the member and/or
 - iii. as Consumer Directed Attendant Care
 - d. DME not included in the institutional facility per diem
 - e. Emergency alert systems
 - f. Habilitation
 - g. Home delivered meals
 - h. Home health aide
 - i. Transition services type that will be authorized in order to transition the NF member to HCBS. This service may be authorized while the member is still in an institutional placement. The case manager must document the date of case review and initiation of transition type (Money Follows the Person MFP) services for reporting to DMMA. This format and schedule of submission of this report will be determined during Implementation Team Meetings. (See CONTRACTOR contract Chapter II section 7.5 DSHP Plus Benefit Package.)
 - j. Hospice
 - l. Respite care, including nursing facility respite
 - m. Therapies (occupational, physical, speech, and/or respiratory)
 - n. Behavioral health services
 - o. Medically necessary non-emergency transportation that is regularly scheduled
(e.g., dialysis three times per week – this is a benefit through the DMMA Transportation Broker contract)
 - p. Home modifications
 - q. Assisted Living Facility services
 - r. Nutritional supplements for individuals diagnosed with AIDS that are not covered under the State Plan. This service is not available to persons residing in Assisted Living and Nursing Facilities.
 - t. Title XIX covered services as noted above, if provided by other funding sources, for example, Medicare and other insurance sources.

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24. Refer to CONTRACTOR Contract Chapter II Section 7.5 DSHP Plus Benefits for descriptions of the amount, duration and scope of DSHP Plus services and settings, including information about restrictions on the combination of services.

E. SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

1. Case managers are responsible for ongoing monitoring of the services and placement of each member assigned to their caseload in order to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers.
2. Member placement and services must be reviewed on-site, with the member present, within the following timeframes:
 - a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in uncertified institutional settings)
 - b. At least every 90 days for a member receiving home and community based services (HCBS)
 - c. At least every 90 days for a member residing in an alternative residential setting
 - d. At least every 90 days for a community-based member receiving acute care services only. Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year.

Contractors may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion but may not determine members to need less frequent visits.

Case managers should attend nursing facility care conferences on a periodic basis as an opportunity to discuss the member's needs and services jointly with the member, care providers and the family. Case managers should at least consult with facility staff during 180-day visits to assess changes in member Level of Care.

3. Review visits must be conducted at the member's residence. A visit made to a site other than the member's place of residence must be at the request of the member or representative, not just for the convenience of the case manager. If an alternate site is used, the rationale must be documented in the case management file. Every effort should be made to see members in their homes in order for the case manager to assess the living environment and evaluate potential barriers to quality care. Visits to an alternative site should be the exception.
4. Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action. More frequent case monitoring is required when the case manager is notified of an urgent/emergent need or change of condition which will require revisions to the existing service plan.

An emergency visit is required when the situation is urgent and cannot be handled over the telephone or when the case manager has reason to believe that the member's well being is endangered.

5. Case managers must conduct an on-site review within ten business days following a member's change of placement type (for example, from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS) or from the date the case manager is made aware of such a change. This review must be conducted to ensure that appropriate services are in place and that the member agrees with the service plan as authorized.

Whenever possible, discharge to a member's own home should be delayed until adequate services can be arranged. In-home services must be initiated within ten business days following a member's discharge to HCBS.

6. If the case manager is unable to contact an enrolled member to schedule a visit, a letter must be sent to the member or representative requesting contact by a specific date (ten business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the case manager must send an electronic spreadsheet with information on member changes in a format specified by DMMA and/or a Member Change Report, indicating loss of contact, to DMMA, for possible disenrollment from the DSHP Plus program. (The Member Change Report will be developed jointly with the Contractors and DMMA during Implementation Team Meetings.)

NOTE – Disenrollment will not occur if DMMA is able to make contact with the member or representative and confirm that the member does not wish to withdraw from the DSHP Plus program.

7. The case manager must meet with the member and/or representative, according to the established standards, in order to:
 - a. Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the case manager must take and document action taken to resolve these as quickly as possible. The CONTRACTOR Grievance and Appeals department must also be advised by the case manager of member grievances and provider issues for purposes of tracking/trending.
 - b. Assess the member's current functional, medical, behavioral and social strengths and needs, including any changes to the member's informal support system. DMMA LTC will continue to complete the PAE for nursing facility members for Level of Care (LOC) at admission. At some time in the future, DMMA may transition this function to the Contractors. The HCBS members must be assessed at least annually by their case manager to determine their nursing facility level of care to establish the basis for comparison of HCBS and nursing facility costs.

- c. Assess the continued appropriateness of the member's current placement and services (documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement)
 - d. Assess the cost effectiveness of services provided and/or requested to the 80% and 100% of institutional care benchmarks and review and reporting to case management supervisors and DMMA as required.
 - e. Discuss the member's perception of his/her progress toward established goals
 - f. Identify any barriers to the achievement of the member's goals,
 - g. Develop new goals as needed and
 - h. Review, at least annually, the CONTRACTOR's member handbook to ensure members/representatives are familiar with the contents, especially as related to covered services and their rights/responsibilities.
8. The member representative must be involved for the above if the member is unable to participate due to a cognitive impairment, if the member is a minor child and/or if the member has a legal guardian.
- If the member is not capable of making his/her own decisions, but does not have a legal representative or member representative available, the case manager must refer the case to the Public Guardian or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file.
9. Members who reside in an out-of-home residential setting must be regularly assessed to determine if it is possible to safely meet the member's needs in a more integrated setting.
10. The case manager must complete a written service plan at the time of the initial visit, when there are any changes in services, and at the time of each review visit (every 90 or 180 days). The CONTRACTOR will present a template for a service plan for review and approval by DMMA as part of the Implementation Team Meeting process. The member or representative must indicate whether they agree or disagree with each service authorization and sign the service plan each time. The member must be given a copy of each signed service plan.
11. The case manager must review, with the member and/or representative, the CONTRACTOR's process for immediately reporting any unplanned gaps in service delivery at the time of each service review for each HCBS member receiving in-home HCBS.
12. The member's HCBS providers must be contacted at least annually to discuss their assessment of the member's needs and status. Contact should be made as soon as possible to address problems or issues identified by the member/representative or case manager. This should include providers of such services as personal or attendant care, home delivered meals, therapy, etc.

If the member is receiving skilled nursing care from a home health agency, contact is required with the service provider more frequently (see Section I).

For members receiving behavioral health services, the case manager shall make contact with the service provider at least quarterly in order to complete the behavioral health consultation.

13. The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order.

If the case manager and PCP or attending physician do not agree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager may refer the case to the CONTRACTOR's Medical Director for review. The Medical Director is responsible for reviewing the case, discussing it with the PCP and/or attending physician if necessary, and making a determination in order to resolve the issue.

14. If the case manager determines during the reassessment process that changes in placement or services are indicated, this must be discussed with the member and/or representative before any changes are initiated. This is especially critical if the changes result in a reduction or termination of services.
15. The member or member representative must be notified in writing of any denial, reduction, termination or suspension of services, when the member or representative has indicated, on the service plan, that s/he disagrees with the type, amount, or frequency of services to be authorized. Refer to the CONTRACTOR contract Chapter II. Section 11 Grievance System. A managed care member's request for hearing and/or appeal is initiated through the member's CONTRACTOR.
16. The case manager must be aware of the following regarding members eligible to receive hospice services:
 - a. Members may elect to receive hospice services. These services may be covered by private insurance or Medicare, if the member has Part A, or if there is no other payer source available.
 - b. The Medicare hospice benefit is divided into two 90-day election periods. Thereafter, the member may continue to receive hospice benefits in 60-day increments. A physician must recertify hospice eligibility at the beginning of each election period.
 - c. The member has the right to revoke the election of Medicare hospice care at any time during the election period and resume DSHP Plus coverage; however, any remaining days of coverage are then forfeited for that election period.

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A member may also at any time again elect to receive Medicare hospice coverage for any other hospice election periods for which they are eligible.

The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (eg. Home Health Aide) will not be covered. Personal Care/Attendant Care Services (including participant directed services) is not considered a duplicative service. If the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor may report such cases to the licensing agency in Delaware.

17. Most nursing facilities that participate in Delaware Medicaid (DMAP) are dually certified as Medicare and Medicaid facilities. Therefore, beds in these nursing facilities may not be designated as Medicare-only. A DSHP Plus member may not be asked to leave a Medicaid-participating nursing facility after his/her Medicare benefit days have been exhausted.
18. In most cases, members must receive a written 30-day advance notice before discharge from a nursing facility as outlined in 42 C.F.R. 483.12. Exceptions may be made when the health and/or safety of the member or other residents is/are endangered.

F. NURSING FACILITY DIVERSION STANDARDS

1. The Contractor shall develop and implement a nursing facility diversion process according to MCO Contract Chapter II Section 7.5.3 Nursing Home Diversion for approval by DMMA. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member.
2. At a minimum the Contractor's diversion process shall target the following groups for diversion activities:
 - a. DSHP Plus members residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;
 - b. DSHP Plus members residing in assisted living facilities who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;
 - c. DSHP Plus members admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility; and
 - d. DSHP Plus members who are placed short-term in a nursing facility regardless of payer source.
3. The DSHP Plus Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified above.

G. BEHAVIORAL HEALTH STANDARD

1. The case manager must ensure there is communication with the PCP and behavioral health providers involved in the member's care and that care is coordinated with other agencies and involved parties.
2. Refer to MCO Contract Chapter II Section 7.6.2 Behavioral Health Benefits for the description of the benefit.

H. OUT-OF-STATE PLACEMENT STANDARD

1. Out-of-state services are covered as provided for under 42 C.F.R., Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to Delaware Medical Assistance Program(DMAP). DSHP Plus members outside the United States are not covered.

This section of the Appendix is intended to address the standards related to the long term placement of members in out-of-state settings. It does not apply to situations in which the member is temporarily absent from the State.

Out-of-state placements may be approved in licensed/certified residential-type settings only (for example, nursing facilities, residential treatment centers, group homes). Personal residences outside of the State of Delaware are not approved placements. Out-of-state facility providers must be registered with DMAP.

The Contractor must submit quarterly reports to DMMA of members who are placed in out-of-State placements and a projected date of the member's return to in-State placement with the following information:

- a. Member name and Medicaid ID#
- b. Name/location of facility where the Contractor intends to place the member, include the facility's DMAP Provider ID (NPI Number).
- c. Description of the member's medical/behavioral condition that necessitates this placement
- d. Description of facility's program(s) that makes this placement appropriate for the member
- e. Information about other in-state placement options ruled out for the member, and
- f. Plan for member's return to a Delaware placement

I. SKILLED NURSING NEED STANDARD

The case manager is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet his/her individual needs.

Non-Institutional Settings

1. The member's initial needs assessment must be conducted by a DMAP registered home health agency if the member is at risk of compromising his/her skin integrity (for example, the member is bed bound, quadriplegic) or if the member has a history of medical instability (for example, frequent seizures, unstable diabetes, COPD). Thereafter, the member will be monitored for skilled nursing need, by the home health agency, within established timeframes and as otherwise necessary.
2. A member who has skilled nursing needs (for example, pressure ulcers, surgical wounds, tube feedings, pain management and/or tracheotomy) must be referred to a home health agency for the initial assessment and the ongoing provision of skilled nursing care as well as monitoring determined necessary by the assessment.
3. The case file must contain documentation from the initial nursing assessment. In addition there must be evidence of quarterly consultations with the provider of the skilled nursing care and documentation of the member's condition and progress until the member no longer requires skilled nursing care.
4. If the member or member representative refuses skilled nursing care, the case manager must inform the member or representative of the possible risks of refusing such care. The case manager must utilize a managed risk agreement to document the reason given for refusing the recommended care and that the member or representative has been informed of the risks. The member or representative should sign this agreement. The member's PCP must also be informed of the refusal.

Institutional Settings

1. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromising his/her skin integrity (for example, the member being bed bound, quadriplegic, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.
2. Every six months, the case manager must consult with the appropriate facility staff and review treatment record and other Level of Care documentation related to the member's condition and progress. The member's progress related to the specific

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skilled nursing need(s) including compliance with prescribed treatments, must then be documented in the case management file.

J. CASE FILE DOCUMENTATION STANDARD

1. Case file documentation must be complete and comprehensive. It must be typed, not hand-written, and the case file must be available through electronic submission. Each case file page should indicate the member's name and Medicaid identification number. Each entry made by the case manager must be **signed and dated**. If electronic records are utilized, the Contractor must ensure the integrity of the documentation. DMMA may request that documentation kept in an electronic system be printed out for purposes of a case file review.
2. Contractors must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).
3. Case files must be kept secured.
4. Contractors are expected to maintain a uniform tracking system for documenting the begin and end dates of those services listed in the Placement/Service Planning Standard section of this chapter, as applicable, in each member's chart. This documentation is inclusive of renewal of services and the number of units authorized for services.
5. Case files must include, at a minimum:
 - a. Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number
 - b. Identification of the member's PCP
 - c. Information from 90/180 day on-site assessments that addresses at least the following:
 - i. Member's current medical/functional/behavioral health status, including strengths and needs
 - ii. The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of residentially placed member
 - iii. The cost effectiveness of DSHP Plus services being provided
 - iv. Identification of family/informal support system or community resources and their availability to assist the member, including barriers to assistance.
 - v. Identification of service issues and/or unmet needs, an action plan to address them and documentation of timely follow-up and resolution.
 - vi. Member-specific goals that will allow the member to gain functional skills or maintain/increase their current functioning level. Goals must be evaluated for appropriateness at each review with progress towards each goal documented and adjustments to goals/services made as necessary. Documentation should reflect member involvement in the development of goals.

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- vii. Member's ability to participate in the review and/or who case manager discusses service needs and goals with if the member was unable to participate, and
- viii. Environmental and/or other special needs.

Information from the initial on-site assessment that includes all items listed in 4 above.

- 6. Copies of the member's placement history and service plans/authorizations. The service plan must be signed by the member or member representative at each service review visit (every 90 or 180 days) and a copy kept in the file.
 - 7. A copy of the contingency plan and other documentation that indicates the member/representative has been advised regarding how to report unplanned gaps in authorized services.
 - 8. Documentation of the choice of a self-directed care option.
 - 9. Notices of Action sent to the member regarding denial or changes of services (discontinuance, termination, reduction or suspension)
 - 10. Member-specific correspondence
 - 11. Physician's orders for medical services and equipment
 - 12. Documentation that a PASRR Level II evaluation, if applicable, have been completed for members in nursing facility placements and that copies are in the facility chart. A copy of the PASRR Level II evaluation, if applicable, must also be retained in the case manager's file. DMMA DSHP Plus LTC Eligibility will provide copies of the PASRR to the Contractor.
 - 13. Provider evaluations/assessments and/or progress reports (for example, home health, therapy, behavioral health)
 - 14. Case notes including documentation of the type of contact made with the member and/or all other persons who may be involved with the member's care (for example, providers)
 - 15. Documentation of the quarterly contact with the behavioral health provider, and
 - 16. Other documentation as required by the Contractor.
6. DSHP Plus member file information must be maintained by the Contractor for a minimum of five years.

K. SERVICE CLOSURE STANDARD

1. Closure of a member's service(s) may occur for several different reasons. The following is a list of the most common reasons. This list is not meant to be all-inclusive:
 - a. The member is no longer DSHP Plus eligible, as determined by DMMA DHSP Plus LTC Eligibility.
 - b. The member is deceased.
 - c. The case manager and/or physician determine that a service is no longer necessary.
 - d. The member or representative requests discontinuance of the service(s) or refuses services.
 - e. The member moves out of State.
 - f. Contact has been lost with the member.
2. Case managers are required to provide community referral information on available services and resources to meet the needs of members who are no longer eligible for DSHP Plus.
3. If the member has been determined ineligible for DSHP Plus, the member or member representative will be informed of this action and the reason(s), in writing, by DMMA. This notification will provide information about the member's rights regarding that decision.
4. If a service is closed because the DSHP Plus Contractor has determined that it is no longer medically necessary, the member must be given a written Notice of Action regarding the plan to discontinue the service that contains information about his/her rights with regards to that decision.
5. When the member's enrollment will be changed to another Contractor, the case manager must coordinate a transfer between the Contractors. This includes transferring case management records from the prior 12 (twelve) months to the new Contractor.
6. The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process.
7. DSHP Plus Case notes must be updated to reflect service closure activity, including, but not limited to:
 - a. Reason for the closure
 - b. Member's status at the time of the closure, and
 - c. Referrals to community resources if the member is no longer DSHP Plus eligible.

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8. A member who is dis-enrolling from DSHP Plus will remain enrolled through at least the end of the month in which the eligibility is terminated.
9. **The member continues to be the responsibility of the Contractor until the disenrollment is processed by DMMA.** Members are eligible to receive medically necessary services through their disenrollment date.
10. When the reason for termination is the member's death, the case manager must end date the service authorization(s) with the actual date of death.

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L. ABUSE/NEGLECT REPORTING STANDARD

1. Suspected cases of abuse neglect and/or exploitation must be reported to:
 - a. Abuse, neglect or exploitation in licensed LTC facilities:
Division of Long-Term Care Residents Protection (DLTCRP)
The Division of Long-Term Care Residents Protection (DLTCRP) is the State licensing agency and the agency charged with investigating allegations of abuse, neglect, and exploitation within licensed long-term care facilities. (Title 29 DE Code § 7971)
 - b. Abuse, neglect or exploitation outside of licensed LTC facilities:
DHSS, Adult Protective Services (APS)
 - c. Non-Abuse, neglect or exploitation in licensed LTC facilities:
DHSS, Office of State Ombudsman (OSO)
 - d. Non-Abuse, neglect or exploitation outside of licensed LTC facilities:
DSAAPD, Community Services Program (CSP);
Division of Public Health (DPH)
2. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, **separate** from the member's case file, that is designated as confidential.
3. Member quality of care issues must be reported to and a resolution coordinated with the Contractor's Quality Management Unit.